MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building
International Trade Center
Horizon Ballroom
1300 13th Street, N.W.
Washington, D.C.

Friday, April 26, 2002
9:00 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
BEATRICE S. BRAUN, M.D.
SHEILA P. BURKE
AUTRY O.V. "PETE" DeBUSK
ALLEN FEEZOR
FLOYD D. LOOP, M.D.
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ALAN R. NELSON, M.D.
CAROL RAPHAEL
ALICE ROSENBLATT
DAVID A. SMITH
RAY A. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.

AGENDA ITEM: CMS's proposed risk-adjustment system for Medicare+Choice -- Scott Harrison

DR. HARRISON: Good morning. I'm here to fill you in on CMS's recent announcement on the development of a risk-adjustment system in the Medicare+Choice program. We are not required to make any formal comments but we might want to do some work over the next year on this issue.

First a brief recap. The idea behind health status risk adjustment is for Medicare to pay plans based on the health risk of the particular beneficiaries they enroll. Doing so provides incentives for plans to compete based on efficiency and quality rather than on the ability to attract a relatively healthy group of enrollees. Also risk adjustment rewards plans for efficiently treating beneficiaries in relatively poor health.

Further, successfully adjusting for health risk is vital for pursuing the Commission's recommendations that the payment system be financially neutral between enrollees in the Medicare+Choice and beneficiaries in traditional fee-for-service Medicare.

Since January of 2000, Medicare+Choice payments have been risk adjusted using a blend of 90 percent of a demographic model and 10 percent of a health status model called the PIP-DCG model which is based on diagnoses collected only from hospital stays. Dissatisfaction with the PIP-DCGs because of the model's low predictive power and uneven treatment of beneficiary health status based on whether or not beneficiaries were treated in the hospital led to a statutory mandate in the Benefits Improvement Protection Act of 2000, BIPA, to include diagnoses from ambulatory data in the risk-adjustment system.

The Medicare program began collecting data on every physician and hospital outpatient encounter of each Medicare+Choice enrollee in order to simulate the effects of the different multisite diagnostic models that were being developed. Last May, Secretary Thompson suspended the collection of ambulatory site data in response to insurer complaints about the burden of the data collection, that it was just too overwhelming. Last month, CMS released its plan for the resumption of data collection and some details on the new risk-adjustment model that it intends to implement in 2004.

In examining different potential risk-adjustment models, CMS was looking to meet several objectives. First it wanted to find a model that would have better predictive power than the PIP-DCG model. Also it was essential for a new model to be implemented in a way that would lower the administrative burden on the plans relative to the full encounter models proposed. In addition, CMS felt that the risk factors should be clinically meaningful so they could be explainable to beneficiaries, providers, plans, and the policy community.

CMS wanted a model that incorporated a wide range of diseases treated by a range of physician specialties so that it would create incentives for plans to contract with a broad spectrum of providers and all the specialties could feel that they contributed revenue to the plan through the needed services

that they provide.

On March 29th, CMS announced the parameters of the new risk-adjustment system. It will be based on the hierarchical condition category, or HCC model, which clinically maps ICD-9 diagnosis codes into disease groups. The full model which CMS was considering using as its full encounter model has 86 disease groups with payment differentials. For its new model, CMS scaled it back a bit and chose a 61-group model, although the exact number and definitions are still being ironed out.

The most common disease group is COPD which contains 13 percent of beneficiaries, and the most costly group is dialysis status which would pay plans an extra $14,000 in 1997 dollars. I should not here that this dialysis group would be for beneficiaries who had acute renal failure requiring dialysis during the base year. It would not include ESRD beneficiaries because they are excluding from the model, and CMS continues to try to find an appropriate risk-adjustment system for them.

As I just implied, the model is prospective in that diagnoses in a base year determine payments in the following year. The model is site neutral: where the diagnosis comes from does not affect the value of the risk adjuster. Some models would have paid more diagnoses that were made in a hospital.

It's an additive model which pays an additional amount for each disease group in which a beneficiary is placed. And there are additional interactive payments for beneficiaries who have selected multiple conditions. I'll show you what I mean in this following example.

In this example we see how the total annual payment would be determined for a 67-year-old man who has uncomplicated diabetes and congestive heart failure. Remember that these numbers are very rough and they're in 1997 dollars.

For being a man between the ages of 65 and 69 the base payment would be $1,700 per year. If the man had no other conditions that would be the total payment, by the way. But for this man there would be an additional payment of $1,200 because he had diabetes, and another $2,300 for having congestive heart failure. The combination of diabetes and congestive heart failure is one of the interactive groups and it would trigger an additional payment of $1,300. So the total for this beneficiary would be $6,500 for a year.

Taking a quick look at the performance of the 61-group model, it seemed to do pretty well in simulations. The model explained 11 percent of the variance in Medicare spending while the PIP-DCGs explained about 6 percent. The model was also much more accurate in predicting the Medicare costs for groups of beneficiaries such as groups by quintile of spending in the base year, and those were some common conditions.

Further, this model performed almost as well as the full HCC model. The difference in the percentage of variance explained is less than half a percent, and the only subgroup where the full model performs noticeably better is for those beneficiaries who spent the least in the base year. So this would still pay a little bit more for the default groups than the full HCC model would.

CMS really seems to have simplified the data submissions as much as possible while still being able to actually operate the model. Plans will be required to submit data only for those diagnoses that trigger additional payment. Plans only need to submit five data fields for each diagnosis. I think that's down from about 50 under the full encounter model. The type of provider and the beginning and ending dates that are three of the variables are really used for audit purposes, although you do need to make sure that the diagnosis was made during the proper base year.

The plan would be responsible for retaining enough data to be able to prove that a diagnosis was actually made during an encounter. Plans would only need to submit data once a quarter and only for enrollees that had a reportable diagnosis that didn't already occur earlier in the year. If it's more convenient for plans CMS will also accept the full encounter data.

When deciding on the number of diagnoses to use in the model there is a trade-off between increasing the accuracy of the model and increasing the burden of data collection. CMS picked a model that had almost as much explanatory power as the full model and reduced the number of disease groups by about 30 percent. I should note here that the model of 61 groups does use over 3,000 different ICD-9 diagnoses codes that get mapped into this groups, so plans still do have to collect a considerable amount of data and some have still expressed some concern about that.

Representatives of plans that specialize in enrolling the frail elderly, such as the social HMOs and PACE plans, have been concerned that this model might result in lower payments to them. They base these concerns on simulations of the impact of the full HCC model that they had done. I think that their test did not include some of these interactive terms which perhaps might produce higher payments for the frail. CMS was aware of these concerns and made an effort to include disease groups that were likely to occur in the frail. The new model really wouldn't apply to these specialty plans however until CMS makes an explicit decision to do so. We may want to monitor this in the future.

We really don't know anything yet about the financial implications of the model. For example, we don't know how much or even whether this model would decrease or increase total Medicare payments to plans. We would monitor this situation as well and look at how much money would move between plans and try to describe the types of plans that would receive higher payments and those that might receive lower payments under the use of this model.

Finally, we have the issue of how CMS will handle the time lag between when diagnostic data is available for enrollees and when payment is to be made based on those diagnoses. At the beginning of 2004 CMS will pay based on diagnoses made between July 2002 and June 2003. The current plan is to move the diagnostic period up to the calendar year and adjust retroactively when the data does not arrive by the beginning of the payment year.

CMS feels that since they're already doing a retroactive adjustment for some of the working aged categories and for institutionalization they don't think that this would be much of a problem. I know Alice in the past has been worried about being able to predict ahead of time what the payments would be.

To sum up, this model development appears to keep CMS on track to begin adjusting payments with a health status model that will include data from ambulatory sources by the statutorily mandated January 2004. It will, however, no longer have the comfort of a trial period. Data will be collected for enrollees beginning this July and that data will actually be used in setting the 2004 payments. The full model, however, won't be fully phased in until 2007. It will be phased in gradually.

Simulations suggest that the new model is greatly improved over the current PIP-DCG model in terms of predictive power in fairness to those beneficiaries who are treated in ambulatory settings. And the plans' burden in submitting data seems to have been reduced relative to the full encounter models that were previously contemplated, but only full implementation will be able to decide whether their burden was lifted.

Questions, comments?

MR. HACKBARTH: So the answers to the questions about the financial implications, whether total payments will go up or down and how they might be redistributed, we won't be able to analyze those questions until we've actually done the data collection, and the schedule now in place really doesn't provide for any analytic phase it's just straight into payment.

DR. HARRISON: That's right.

MR. HACKBARTH: So the plan will proceed without having answered those questions.

DR. HARRISON: Correct.

MR. HACKBARTH: Before I forget, Joe Newhouse had one issue that he wanted to raise. Did he talk to you directly about it? His issue was that with regard to physician payments, the physician side of this, he think there's going to be significantly undercoding of the diagnosis information. So if you leap into this there will be a big opportunity to upcode which could result in much higher than anticipated expenditures. So he would slow down the phase-in. Give people enough of an incentive to do the proper coding at the first step but not make too much of the payment based on the new system until you've actually got better coding information.

Does that make sense to you? Did it come out clearly at least?

DR. HARRISON: Yes, certainly we could be worried about that since we'll have no information ahead of time really.

MR. HACKBARTH: So he would like any comment we make to suggest slower phase-in of this while we figure out what the system means.

MS. BURKE: Just a side note, not that I think there's anything we can do about it. But having gone through this on a couple of occasions I think the chances of there not being a fair amount of hue and cry once the distributional analysis is done and we begin to see a reallocation of assets based on risk

adjustment, the likelihood that Congress will not intervene if there are huge shifts is around zero I should think.

So as we begin to anticipate, I just can't imagine if in fact it shows any real shifts in terms of payment rates in some of those areas you've got to believe that they're not going to sit by and let that happen, whether they do a zero sum game or something. I don't know how we anticipate that but I think we have to anticipate that that, unless something changes, is likely to occur.

MS. ROSENBLATT: I'm just wondering if there's a way we can do some analysis. Would it be possible to approach some plans and get some data for -- instead of waiting for the 2002 to 2003 data that's going to be used, can we go backwards and get some 2001 data and project what would have happened in 2002?

DR. HARRISON: We've tried to do that in the past and every time we do the plan then figures out that they really don't have the right data. We can try and if any plans have data we'd be happy to --

MS. ROSENBLATT: Unfortunately, Wellpoint's population is not a very large population and Janet is not here, but maybe between PacifiCare and Aetna, if they were willing to give some information -- I mean, it seems to me that's the key question in everything you raised here, the financial modeling.

I think we've all moved past the model. I'm willing to take, based on what you're saying, that this model is better than the existing PIP-DCG. I don't think that the value we bring is in saying, maybe there's a better model out there. Let's just accept that this is an okay model and is a nice compromise in terms of the data. But then the issue is, we've got a system that is very broken; is this going to break it even more?

DR. HARRISON: I've heard some comments from plans that suggest they don't care because it's not going to apply to them because they won't be here, which actually is a problem for data collection too because if a plan announces they pull out July 1st are they going to bother collecting the data that will be needed to code their beneficiaries in the next year?

DR. LOOP: I don't think this is going to work because when the statisticians get to this the change in r-square from 0.06 to 0.11 may be twice as good as it was but it's still pretty bad. You want to comment on that?

DR. HARRISON: I know Joe always says that you probably couldn't explain more than 20, 25 percent anyway; the rest of it really is random. So I don't know whether he would think 11 is good, but it seems a lot better. It could be that they're explaining half of what's potentially explainable.

DR. LOOP: The other point I wanted to make is that those who will have concern about payment for the frail elderly, I think their concern is validated in Table 2 because the predictive power really declines as you get into higher and higher cost quintiles.

MR. HACKBARTH: Scott, those organizations are now paid based on a negotiated rate?

DR. HARRISON: Social HMOs, I believe, are paid still based on the old AAPCC with their own little system, and I think PACE

plans are as well; gets the frailty adjustment.

MR. HACKBARTH: Their concern is that they not be moved automatically into this new system but considered separately?

DR. HARRISON: Correct, and we as a commission have also said that in the past, that we should make sure that it would work before we move them.

DR. REISCHAUER: I'd just like to reemphasize Joe's point but from a different perspective. He was worried about the uncertainty with respect to total federal spending, and I'm worried much more about the business side of this, that this introduces an element of tremendous uncertainty. If I were running a business, not knowing how this was going to come out, if I were thinking of withdrawing before I would be totally convinced that that was the right move now.

If we have a desire to keep this endangered species alive in the hopes that out of it might come some future Medicare reform I think it would be wise to suggest that, given that administrative action was taken to delay this whole thing, that Congress consider pushing off the implementation for a year just so people can know what kind of world they're going to be moving into.

MR. HACKBARTH: The likelihood, as Sheila points out, that it's going to happen is high to begin with. You could end up with the worst of both worlds, where it is in fact delayed but only after damage is done and people have done anticipatory pull-outs.

DR. REISCHAUER: But we have a chance to start a debate that could occur in sort of a crisis atmosphere and after any good that might come from the result has been blown away.

MR. HACKBARTH: So we've not been asked to specifically comment on this by the Congress; is that right?

DR. HARRISON: No, this announcement was actually in the form of a letter from a CMS official to the plans. So they're really plan instructions. What the announcement does is it limits what -- it tells the plans, you're going to have to collect these codes. You won't ever have to collect other codes, at least for the initial phase. So it lets the plans plan how to collect the data. There is no other force of law. They can end up dropping codes. They can fiddle around a little bit --

MR. HACKBARTH: So CMS is in a position where they're trying mightily to meet the statutory deadlines that are already established and have been in place for years now, and our concern is that given where we are at this point in time and the amount of work that remains to be done that that may not be a reasonable thing to do, but it's Congress that has to change the schedule. So what we would be doing is offering our unsolicited opinion to the Congress that maybe they ought to give CMS some more space to do the analysis on this?

DR. HARRISON: Right.

MS. BURKE: Can we just look at the schedule that you included in our books for just a second so we understand? One of the things you could imagine happening
-- this is as I recall and I was checking, is phased in on fractions over time. So you might imagine a scenario that has them hold it at 30/70 for three -- I mean, you could imagine the

Congress trying to intervene in a variety of ways.

When do you anticipate the plans will actually begin to collect the data that is now going to be required on the 61 diagnoses? And at what point, to Alice's point, at what point could you imagine our saying, all right, let's do a data run and figure out what in fact this will look like? We've done that before. We did that when we transitioned in the past. So the question is, at what point will the plans have done this that we could actually run a model?

DR. HARRISON: They are supposed to submit data by October retroactively to July. So in other words, things that happened to patients from July on are supposed to be reported.

MS. BURKE: This coming July?

DR. HARRISON: Yes.

MS. BURKE: Who's bright light was it that did it prospectively instead of retrospectively so that behavior can already begin to shift? You could imagine all sorts of crazy things occurring. You've identified the 61 and now you're telling them four months out that that's what you're going to look at?

DR. HARRISON: Right. Now they were actually collecting data before it was suspended.

MS. BURKE: But they're not going to go back.

DR. HARRISON: No, because they suspended it between May of last year and July of this year.

MS. BURKE: One of the first questions I'd want to look at is whether you see a change in pattern at all. They ought to back up at least six months, if they can, if they've begun to collect it. At what point could they in fact run the model?

DR. HARRISON: It is possible -- I had heard that plans were continuing to submit data and I don't know whether CMS accepted it throughout this whole period. We could go back and see if they actually did get a substantial amount.

MS. BURKE: That's a good question to ask.

MR. HACKBARTH: But Joe's point, as I understand it, is that the reporting may change but it actually may be moved towards more accurate reporting. So if you look back, you're not necessarily getting the pure right answer by looking back. You may be getting just an even more inaccurate answer.

MS. BURKE: No question, but we don't know that. It could err on either side.

MR. HACKBARTH: We don't. It's a hypothesis.

MS. BURKE: I think Joe may well be right. But it would seem to me, getting a sense of how quickly one could have enough data to actually run at least the model is the question we're asking, so that you can begin to see what kind of shifts there would be.

DR. HARRISON: I would think it wouldn't be till the end of the year.

MS. ROSENBLATT: Because you're assuming that you can't -- I would think, Sheila, that plans who aren't -- some plans probably have the capability to run models now.

MS. BURKE: Right.

MS. ROSENBLATT: It depends on how the plans are reimbursing

the providers and what data they're collecting on their system.

DR. HARRISON: I have heard that some plans have done internal analyses and are actually quite happy.

MR. HACKBARTH: So where do we stand? Should we, or do we ever write unsolicited letters to Congress or the committees making suggestions about this sort of stuff, changing the schedule?

DR. ROSS: You're certainly free to do it. The question is the strength of feeling the Commission has and the knowledge base on which to put that strength of feeling. A vague letter of, oh, there's new information and we don't know what to make of it wouldn't be particularly helpful. I think if we could start to get something, either preliminary runs --

MS. BURKE: Do we know enough, Glenn, today to ask for a delay, or are we asking in fact what's out there that we could use to look at in anticipation of this? Because it doesn't occur to '04. They have a phase-in starting in '04 and the question is, do you want to delay '04 based on what we think may be a problem or do we want to ask -- can we do some initial analysis now before deciding whether or not a delay is appropriate?

DR. ROSS: And recall that you're on record in a number of reports as expressing implementation of risk adjustment as quickly as possible.

DR. HARRISON: One possibility could be we're currently paying 10 percent of a risk adjuster. Switching this one for the hospital one in '04 and maybe suggesting that we not go to 30 but go to 10 might perhaps slow things down enough to see what's happening.

MS. BURKE: Again I don't think we know. We're guessing it's going to have a disproportionate effect but we don't know the answer to that.

DR. REISCHAUER: But the problem is we won't know until after the fact and there's an uncertainty issue here. It strikes me that couldn't we sniff around and see if Congress would find it beneficial if we expressed this discussion.

MR. HACKBARTH: In a somewhat analogous situation where -- my old group was completely prepaid, so there was no incentive to code information correctly, no apparatus to do it. Then we had to start doing it because of self-insured employers demanding claims data and it began to affect payments, revenues to the organization. The impact is huge. People had no reason to pay attention to that. Now they do. I think that's the problem that Joe is identifying and the consequences could be very large for total program spending and for the distribution of the dollars.

I think it's more than just a vague concern out there. I think in some similar situations you've seen the sort of problem that could arise, so I feel some anxiety about this. Now whether now is the time to write the letter or it's six months from now, I don't know. I don't know what better information we're going to have and exactly when we're going to have it. Maybe that's the question you can help clarify for us, Scott.

DR. HARRISON: It's hard to think that we would have any meaningful data before the end of the year, and even that could be sketchy. Unless CMS has been collecting data all along,

perhaps some plans may be in a position to give us data, or CMS might be able to give us the data on some plans but it certainly wouldn't be the whole universe.

DR. REISCHAUER: But what is some data going to tell us? Some plans are going to be positively affected and some are going to be negatively affected. Us coming forward with the three plans that are positively affected isn't going to reduce the anxiety of some plan that doesn't have the data and is unsure.

MR. HACKBARTH: Going back to Murray's earlier point about our being on record as saying as quickly as possible, what we're doing is defining as quickly as possible. I don't think it is as quickly as possible to just close your eyes and say we're going to leap into the darkness. We could do that right as we speak. You know, let's just make up a system. That's not prudent policy.

DR. ROSS: Let me offer a suggestion because I think what you need then next is at the retreat to be able to have at least an analytic discussion and whatever additional information we have on timelines, whatever we've gleaned, whatever indications we're getting from the plans, and then to have a discussion of this and presumably the larger issue of again whither Medicare+Choice or what you think you want to be saying over the coming year. Whether it will be just a continuing reiteration of the so-called payment neutrality, expressions of potential concern about risk adjustment.

My gut instinct is along with Joe's, that most of the uncertainty about this in the short run is pretty one-sided. Yes, it adds uncertainty to some business decisions, but given the coding issues most of that is going to be pumping more money into the system, not less.

We won't be able to bring you a whole lot more data between now and the retreat but what we can do perhaps is set something up to help guide your thinking on it.

MR. HACKBARTH: But a better understanding of the timeline would help me. I may be slow on the uptake, but I still don't have a handle on exactly what we're going to have.

DR. HARRISON: In July --

MR. HACKBARTH: I don't think we need to do it right now. As a matter of fact, maybe you and I can talk separately and I can get smarter about it. The real issue on the table is if we want to send a letter to Congress, when do we send it? Is it something we send now or should we wait for some additional opportunity to look at analysis or data to help us think about that.

MS. ROSENBLATT: Glenn, I'm just wondering, is there a way to simulate the analysis, not worry about collecting the data but just make some assumptions about -- getting to Joe's point, if getting the data resulted in X, and we're phasing in 30 percent, what would that do to total Medicare spending in 2004. That type of analysis, it's back of the envelope kind of analysis, but it at least puts some parameters on it and might get the juices flowing, so to speak, of what might occur.

DR. REISCHAUER: Is it possible to -- we've brought a lot out on the table here. We'll know a little bit more. We can

sniff around a bit and have a short discussion at the retreat on this.

MR. HACKBARTH: Yes.

DR. REISCHAUER: Because I don't think now versus the retreat is critical.

DR. NELSON: If Congress wants to try and resuscitate Medicare+Choice, there are two ways to do it. One is an arbitrary across the board, pump more money in in a way that has no rational basis for it.

The other is to do it in a way based on severity of illness and at least have some logic.

So I guess the point that I'm making is that we ought not to necessarily fear increasing spending for this particular part of the program, because if plans keep dropping out of Medicare, Congress is going to have to do something one way or another if it wants to retain Medicare+Choice.

MR. HACKBARTH: I can't remember which meeting it was, maybe it was January, when we last discussed Medicare+Choice and our view of it. The consensus, what came out in our report, was that we think we should pay the same amount whether the beneficiary chooses traditional fee-for-service or a private plan. We shouldn't pay more to private plans just to bail out the Medicare+Choice program so that it stays around. We need to, as quickly as possible, improve the risk adjustment in Medicare+Choice.

I don't want to go back and review still again, for the fourth or fifth time, our basic principles about Medicare+Choice. This is a narrow question now about is this an improved risk adjustment and when it should be implemented, how it should be implemented.

And so that's the conversation that I think we need to have in July, and there's no rush to have it before July, with a little better understanding of what the timetables are. At that point we can then make a judgment about what, if anything, to say to Congress about the schedule.

DR. NELSON: I'm not arguing that point at all. I'm certainly not arguing for us to abandon our previous principles. The context for my comments were in concerns I heard about well, maybe this will lead to increased spending because we will be making severity adjusted payments without sufficient experience on what the cost impact is going to be.

As a matter of fact, if we were to do so and it was consistent with our original principle, which is if there's an increased severity of illness that needs to be acknowledged and paid for, let's do it. That's still with a neutral public policy.

MR. SMITH: Alan, I don't think the concern is whether there would be more spending or less spending or whether or not the proposed system is a better risk adjustment system than the current one. I think the question is distribution, as I heard Bob raising it, is whether or not the consequences of a better system that more appropriately pays on a risk adjusted basis further adds to the difficulty of the program.

Now whether or not that's a good basis for us to make a

judgment or not, I think is a different question. I don't think the concern here is that spending might go up. That would be a consequence of what we think is a better way of determining spending. The question is whether spending would be redistributed either in anticipation of redistribution or because of redistribution more plans would leave.

DR. NELSON: I misunderstood what Joe was trying to say through Glenn, because I thought the concern was that spending would go up.

MR. SMITH: That is Joe's concern, I think.

DR. ROSS: The point I was trying to make is that concern offsets or mitigates somewhat the other concerns about uncertainty about changing systems. To the extent it does induce additional spending, it also greases the wheels a little bit on the redistribution.

DR. REISCHAUER: But the problem is, as Alice pointed out, is two things are happening. You're introducing a better risk adjuster and you're going to 30 percent, and they work in opposite directions probably, maybe.

DR. BRAUN: I guess if we're concerned about redistribution problems, shouldn't it be redistributed according to the illness of the patients? It will encourage the plans.

MR. HACKBARTH: Yes, and that's the whole reason you do the risk adjustment is to achieve appropriate redistribution. So that's not a bad thing in and of itself. Again, I think the issue here is a narrow one. Do we understand what we're doing before we do it? Do we create such anxiety by truncated time schedules that people just drop out? I don't want to hang around and find out. This is the last straw for me, thank you, I'm out of here. That wouldn't be constructive.

I think we've exhausted it for now but we can take it up again, the timing issue, in July. Thanks.